COLORADO DEPARTMENT OF PUBLIC HEALTH & ENVIRONMENT
Acute Hepatitis B Questionnaire

For confirmed, probable & suspected cases of acute hepatitis B
{Questions marked with a * are those that must be entered into the CEDRS record}

***Patient Name**_____ **CEDRS #** _____
***Address**_____ ***Phone (hm)** _____
***City** _____ ***County**_____ ***ZIP**_____ ***Phone (wk)**_____
***DOB**_____ ***Age (years)**_____ ***Sex: M F**
***Date reported to public health** ___/____/____

***CONSENT: "**All of your responses will be handled in a confidential manner to the extent allowed by the law". **Date this statement was verbally told to the patient:** ___/ ___/___

***DEMOGRAPHIC INFORMATION:**

***Race:** (check all that apply) ☐ American Indian/Alaska Native ☐ Asian ☐ Black ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other race
If other, please specify _____
***Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Other/Unknown
***Place of birth:** ☐ USA ☐Other country:_____
***Physician:** (name, address, and phone number)_____
_____

***CLINICAL AND DIAGNOSTIC DATA:**

***Reason for testing:** (check all that apply)

☐ Asymptomatic patient with no risk factors ☐ Prenatal
☐ Asymptomatic patient with risk factors ☐ Symptoms of acute hepatitis
☐ Blood/organ donor screening ☐ Unknown
☐ Evaluation of elevated liver enzymes ☐ Other (specify)_____
☐ Follow-up testing for previous marker of viral hepatitis

***CLINICAL DATA / SYMPTOMS:**

***Is or was patient symptomatic?** ☐ Yes ☐ No ☐ Unknown
***If yes,** onset date: ___/___/____
***Did the patient experience? (answer for each symptom below)**

Abdominal Pain	☐ Yes ☐ No ☐ Unk	**Fever**	☐ Yes ☐ No ☐ Unk
Arthralgia	☐ Yes ☐ No ☐ Unk	**Jaundice**	☐ Yes ☐ No ☐ Unk
Clay Colored Stool	☐ Yes ☐ No ☐ Unk	**Loss of Appetite**	☐ Yes ☐ No ☐ Unk
Dark Urine	☐ Yes ☐ No ☐ Unk	**Nausea**	☐ Yes ☐ No ☐ Unk
Diarrhea	☐ Yes ☐ No ☐ Unk	**Vomiting**	☐ Yes ☐ No ☐ Unk
Fatigue	☐ Yes ☐ No ☐ Unk	**Other**	☐ Yes ☐ No ☐ Unk

If other, please specify_____

*** Patient hospitalized for hepatitis?** □ Yes □ No □ Unknown
*** Is patient insured?** □ Yes □ No □ Unknown
If yes, □ Public □ Private □ Unknown
If Privately insured: □ Private Plan □ Military Plan □ CHIP
If Publically insured: □ Medicaid □Other
If other, please specify_____

*** Patient currently pregnant?** □ Yes □ No □ Unknown
Due date: ___ /___/_____
***Did the patient die from hepatitis?** □ Yes □ No □ Unknown **Date of death ___/___/___**

***SEROCONVERSION:**

Did patient have a previous negative HBsAg test in the previous 6 months?
□ Yes □ No □ Unknown
If yes, where tested: _____
Test date (verified): ___/___/___

***DIAGNOSTIC TESTS:**

***Date when (1st) blood drawn for hepatitis B testing? ___/___/___**

***Reporting Laboratory**_____
***HAV/HBV/HCV serology results: start below (check all that apply)**

***Total antibody to hepatitis A virus [total anti-HAV]**
□ Positive □ Negative □ Unknown □ Not done

***IgM antibody to hepatitis A virus [IgM anti-HAV]**
□ Positive □ Negative □ Unknown □ Not done

***Hepatitis B surface antigen [HBsAg]**
□ Positive □ Negative □ Unknown □ Not done

***Total antibody to hepatitis B core antigen [total anti-HBc]**
□ Positive □ Negative □ Unknown □ Not done

***IgM antibody to hepatitis B core antigen [IgM anti-HBc]**
□ Positive □ Negative □ Unknown □ Borderline □ Not done

* **Antibody to hepatitis C virus [anti-HCV]**
□ Positive □ Negative □ Unknown □ Not done
***anti - HCV signal to cut-off ratio**_____

***Supplemental anti-HCV assay [e.g., RIBA]**
□ Positive □ Negative □ Unknown □ Not done

***HCV RNA [e.g., PCR]**
□ Positive □ Negative □ Unknown □ Not done

***Liver enzyme values:**
***SGPT (ALT)** _____ Test date: ___/___/____ Upper limit normal: _____
***SGOT (AST**) _____ Test date: ___/___/____ Upper limit normal: _____
Other tests _____

*VACCINATION HISTORY:

***Has the patient ever received hepatitis A vaccine?** □ Yes □ No □ Unk
If yes, how many doses? □ 1 □ ≥ 2
Year of the last Hepatitis A dose: _____
***Has the patient ever received hepatitis B vaccine?** □ Yes □ No □ Unk
(***If yes, record vaccine history below)***

Hepatitis B Vaccination Date (Month, Day and Year):

Dose 1:Vaccine Type:_____**Brand Name:**_____
Manufactor:_____**Date Given:**___/___/___**Lot #:**_____

Dose 2:Vaccine Type:_____**Brand Name:** _____
Manufactor:_____**Date Given:**___/___/___**Lot #:**_____

Dose 3:Vaccine Type:_____**Brand Name:** _____
Manufactor:_____**Date Given:**___/___/___**Lot #:**_____

***Was the patient ever given Immune Globulin?** □ Yes □ No □ Unk
If yes, what **month/year** was the last dose received? ___/___.

*LIVER SPECIALIST:

Is patient seeing a provider for HBV management? □ Yes □ No □ Unknown
If yes,
Name: _____

Address: _____

City: _____

Zip Code: _____

Phone Number: _____

Fax Number: _____

Has patient ever taken medication for HBV? □ Yes □ No □ Unknown

*PATIENT INFORMATION/HISTORY:

***During the *6 weeks – 6 months* prior to onset of symptoms, was the patient a contact of a person with confirmed or suspected acute or chronic hepatitis B virus infection?**
□ Yes □ No □ Unk
If yes, was the contact: (check all that apply)
□ Donor □ Household Member (non-sexual) □ IDU □ Nosocomial □ Occupational
□ Other □ Perinatal □ Sex Partner □ Unknown
If other, please specify _____

***In the *6 months* before symptom onset,**
(Ask both of the following questions regardless of the patient's gender)

	0	1	2-5	>5	Unk
How many male sex partners did the patient have?	□	□	□	□	□
How many female sex partners did the patient have?	□	□	□	□	□

*Of the sex partners you had during the last 6 months how many did you find through the intranet? _____Total #

***Was the patient *EVER* treated for a sexually transmitted disease?**
□ Yes □ No □ Unk
If yes, which disease(s):_____
What was the **year** of most recent treatment:_____

***During the *6 weeks – 6 months* prior to onset of symptoms,**
1. *Did the patient inject drugs not prescribed by a doctor? □ Yes □ No □ Unk
If yes, what was patient's drug of choice? _____ & how long have you been shooting? _____

2. *Did the patient use street drugs (not injected)? □ Yes □ No □ Unk
If yes, what was patient's drug of choice? _____
2a. Have you been prescribed medical marijuana? □ Yes □ No □ Unk

3. *Undergo hemodialyisis? □ Yes □ No □ Unk
If yes, **month and year** of hemodialysis _____

4. * Did the patient have an accidental stick or puncture with a needle or other object contaminated with blood? □ Yes □ No □ Unk

5. *Did the patient receive blood or blood products [transfusion]? □ Yes □ No □ Unk
If yes, date of transfusion? (___/___/____)

6. *****Did the patient receive any outpatient IV infusions and/or injections?
□ Yes □ No □ Unk

7. Patient diabetic? □ Yes □ No □ Unk
If yes, has patient shared diabetic supplies? □ Yes □ No □ Unk
If yes, □ Family □ Friend □ Roommate □ Other
If other, please specify_____

8. Have you ever been told by a doctor that you have diabetes? □ Yes □ Yes, pregnancy related □ No □ No, pre-diabetes or borderline diabetes □ Don't know
If yes, when were you first told by a doctor that you have diabetes? □ < 6 months prior to symptom onset □ ≥ 6 months prior to symptom onset □ Don't know

9. *Did the patient have other exposure to someone else's blood? □ Yes □ No □Unk
If yes, please specify_____

10. *Was the patient employed in a medical or dental field involving direct contact with human blood? □ Yes □ No □ Unk **If yes**, what was the frequency of the direct blood contact?
□ Frequent (several times weekly) □ Infrequent

11. *Was the patient employed as a public safety worker having direct contact with human blood? □ Yes □ No □ Unk
If yes, please specify □ Correctional Office □ Fire Fighter □ Law Enforcement Officer □ Other
What was the frequency of the direct blood contact?
□ Frequent (several times weekly) □ Infrequent

12. ***Did the patient receive a tattoo? □ Yes □ No □ Unk
If yes, where was the tattooing performed? (check all that apply)
□ Commercial Parlor/Shop □ Correctional Facility □ Other
If other, please list_____

13. *Did the patient have any part of their body pierced (other than ear)?
□ Yes □ No □ Unk
If yes, where was the piercing performed? (check all that apply)
□ Commercial Parlor/Shop □ Correctional Facility □ Other
If other, please list_____

14. *Did the patient have dental work or oral surgery? □ Yes □ No □ Unk

15. *Did the patient have surgery (other than oral)? □ Yes □ No □ Unk

16. * Was the patient hospitalized during the incubation period? □ Yes □ No □ Unk

17. *Was the patient a resident of a long-term care facility (i.e., Nursing Home)?
□ Yes □ No □ Unk

18. *Was the patient a resident of an inpatient or outpatient drug treatment program?
□ Yes □ No □ Unk **If yes**, circle one of the following: **inpatient** or **outpatient**

19. *Was the patient a resident of a half-way house? □ Yes □ No □ Unk

20. *Was the patient incarcerated for longer than 24 hours? □ Yes □ No □ Unk
If yes, what type of facility? □ Jail □ Juvenile Facility □ Prison

21. * During his/her lifetime, was the patient **ever** incarcerated for longer than 6 months?
□ Yes □ No □ Unk
If yes, what year was the most recent incarceration? _____ For how long? _____

22. *Patient **EVER** have clotting factor? _____(enter year)

23. *Patient **EVER** have an organ transplant (any type)? _____(enter year)

♦ Information from questions marked with a * should be entered into CEDRS. If unable to enter record into CEDRS surveillance form can be faxed to the Viral Hepatitis Program at 303-759-5257. ♦ Questions contact the Viral Hepatitis Program at 303.692.2780.

Please complete CASE MANAGEMENT (page 6) and fax to the Viral Hepatitis Program at 303-759-5257

HEPATITIS B / CASE MANAGEMENT:

Case Name: _____CEDRS#:_____

1. **Patient** referred for HIV testing? □ Yes □ No
2. **Patient** referred for anti-HBs (surface antibody) & HBsAg testing 6 months after symptoms? □ Yes □ No *(VHP Staff will follow up with patient in 6 months to confirm HBsAb & HBsAg testing)*
3. **Patient** referred for hepatitis A vaccine? □ Yes □ No
4. Total number of **contacts** referred for hepatitis B vaccine. _____
5. Total number of **contacts** referred for hepatitis A vaccine. _____

CONTACTS

Name of Contact	Age/ DOB	Locating Information Phone/address	Type of Exposure (IVDU, blood exposure, sex)	Exposure Date (m/d/yr)	HBsAg test? Y/N & where?	Lab Date & Result	Vaccinated? Y/N Date & where?
1.							
2.							
3.							
4.							

NOTES:

Interviewer Name: _____ ***Interview Date:*** ___/___/___

Agency: _____

Fax page 6 to the Viral Hepatitis Program 303-759-5257